NOAA Form 57-03-53
(7-12)

U.S. DEPARTMENT OF COMMERCE
NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION

REPORT OF MEDICAL HISTORY – OBSERVER DIVER

LAST NAME	FIRST NAME	MIDDLE NAME	DATE of BIRTH	DATE

WORK ADDRESS	WORK PHONE NUMBER
	WORK E-MAIL ADDRESS
	CELL PHONE NUMBER

STATEMENT of PRESENT HEALTH	AGE	GENDER
	HEIGHT (inches)	WEIGHT (pounds)

CURRENT PRESCRIPTION and NON-PRESCRIPTION MEDICATIONS (Indicate dosage, frequency and condition being treated)	ALLERGIES (List all insect bites / stings, foods and medicines)

CURRENT / PAST MEDICAL HISTORY: Do you currently have or have you ever had the following? Check each item.

	YES	NO		YES	NO
Tuberculosis or positive TB test	☐	☐	Aneurysm, frequent or severe headaches	☐	☐
Exposed to someone who had tuberculosis	☐	☐	Other neurologic disorder or injury	☐	☐
Asthma or any breathing difficulty	☐	☐	Prolonged bleeding, blood clot or embolism	☐	☐
Lung squeeze or collapsed lung (pneumothorax)	☐	☐	Heart murmur or other disorder	☐	☐
Thyroid trouble or goiter	☐	☐	High or low blood pressure	☐	☐
Ear infection or ruptured ear drum	☐	☐	Abnormal heart anatomy or patent foramen ovale	☐	☐
Inability to equalize middle ear pressure	☐	☐	Depression, anxiety or claustrophobia	☐	☐
Bone, joint or other deformity	☐	☐	Been evaluated or treated for a mental condition	☐	☐
High or low blood sugar	☐	☐	Difficulty performing moderate to heavy exercise	☐	☐
Recent unexplained weight loss or gain	☐	☐	Diabetes, high cholesterol, stroke or heart disease	☐	☐
Head injury, memory loss or amnesia	☐	☐	Parent or sibling with diabetes, stroke or heart disease	☐	☐
Concussion or period of unconsciousness	☐	☐	Treated in a decompression chamber	☐	☐
Seizures, convulsions, epilepsy or fits	☐	☐	Decompression illness (symptoms of both AGE/DCS)	☐	☐
Dizziness or fainting spells	☐	☐	Currently pregnant / may be pregnant (women only)	☐	☐

Indicate the type and frequency of use for the following.

Alcohol	Tobacco	Recreational drugs

Indicate date, location and reason for each hospitalization and surgery, had or advised to have. Indicate the reasons for any declined surgery.

Provide a detailed explanation for each item checked "YES" in either Medical History section. Add additional pages if necessary.

APPLICANT CERTIFICATION:
I certify that I have reviewed the medical information provided by me. It is true and complete to the best of my knowledge. I understand that falsification of information on a Government form is punishable by fine and/or imprisonment and that incomplete information may delay or prevent my qualification for dive duty.

APPLICANT NAME	APPLICANT SIGNATURE	DATE

EXAMINER CERTIFICATION: (MD/DO/NP/PA only)
I certify that I have reviewed the medical information provide to me by the applicant listed above. (Check one)

☐ I have not found any medical conditions which preclude the applicant from diving certification.
☐ I have found medical conditions which preclude the applicant from diving certification, see summary of defects listed below.

EXAMINER SUMMARY of DEFECTS

EXAMINER NAME and TITLE	EXAMINER SIGNATURE	DATE

SUPERSEDES NOAA Form 56-76 (2-09)